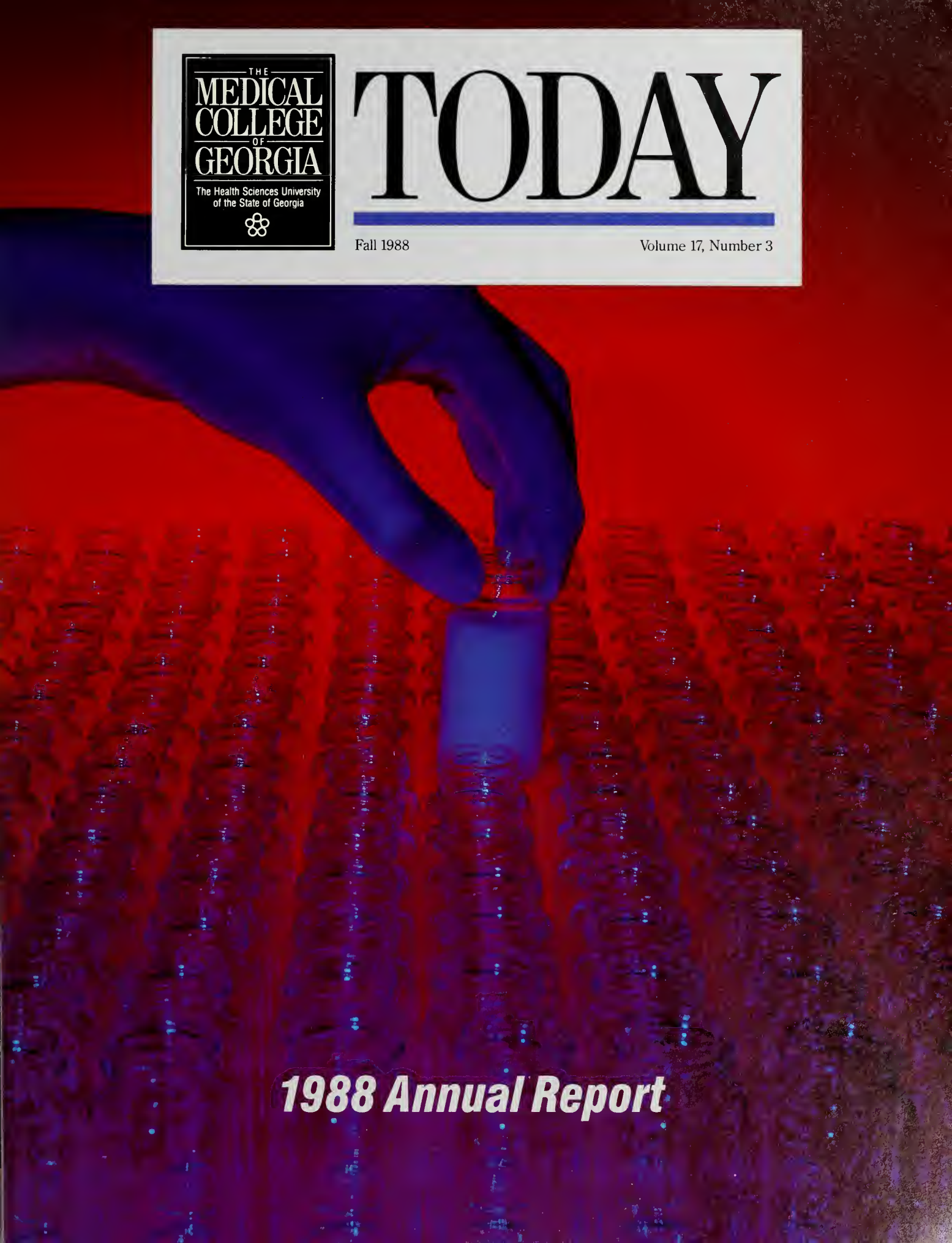
THE MEDICAL COLLEGE OF GEORGIA
The Health Sciences University of the State of Georgia

TODAY

Fall 1988 Volume 17, Number 3



1988 Annual Report

Introduction

The Annual Report issue of *Medical College of Georgia Today* attempts to highlight the school's best and brightest. No small task. MCG, with its 2,200-plus student body (including more than 400 residents) and 6,000-plus employees (including more than 1,400 full- and part-time faculty), is a wellspring of achievement. The subjects included in this magazine are but a representation of the research, education and patient care MCG has excelled at for 160 years, and the people who make it happen.

People like Dr. Francis J. Tedesco, MCG's sixth president. Dr. Tedesco joined the MCG faculty 10 years ago as chief of the section of gastroenterology. Soon thereafter, he was named vice president for clinical activities, then interim dean of the School of Medicine. He became president July 1. His life on and off campus is profiled.

People like Dr. Gloria Clayton, a School of Nursing faculty member studying vibrancy among the oldest old. Her study participants are truly inspiring, as is the confirmation that old age needn't be synonomous with passivity and infirmity.

People like Ron Courson, a physical therapy student who tested his talents in the pinnacle of arenas: He was an athletic trainer for the 1988 Summer Olympics held in Seoul, South Korea.

Turn the page to meet these three and others like them.

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The Medical College of Georgia is the health sciences university of the University System of Georgia. Focusing on health care education, research and patient care, the Augusta-based institution consists of MCG Hospital, more than 80 support clinics, statewide outreach programs and the Schools of Allied Health Sciences, Dentistry, Graduate Studies, Medicine and Nursing.

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Commitment to Success

Dr. Francis J. Tedesco brings values learned in childhood to his presidency at the Medical College of Georgia.

John Tedesco's motto was work hard and success will follow.

He was living proof.

He came to the United States from Italy, a teenager leaving behind his family for the opportunities of this country.

He worked his way up to manager of a copper mill factory; eventually bought a liquor store, one of the largest in Connecticut; and made wise property investments.

John Tedesco also made wise personal investments.

He met and married Lena Tufano. Together they brought into the world four sons: John, Dominick, Francis Joseph and Michael.

They were to lose their youngest, Michael, at age 12 from pneumonia. The tragedy left permanent scars.

But the family was close and, by nature, strong.

John Tedesco was a tough father. There was a joke between the brothers. "If somebody would ask us if we wanted something to eat, we ended up looking at my father to see if we were hungry. That sounds like it was very tough," said John Tedesco's third son, Francis Joseph. "But actually it was a very caring environment."

Everyone had chores and responsibilities. But there were also the Sunday afternoon visits to the beach and summers at the shore.

"My father never had a formal education," said Francis Joseph. "The day he died, he still spoke broken English. But he was one of the smartest people I've ever known. He was very precise at how he did things. He taught us the value of hard work. He also taught us that if you give someone your word, you have to fulfill it."

Lessons learned long ago have endured.

John Tedesco, the eldest son, is now an executive for Bell Telephone.

Dominick Tedesco, the second son, was an executive with Xerox. He died in October.

And Dr. Francis J. Tedesco is the sixth president of the Medical College of Georgia.

The third son already had all the credits he needed to graduate by the end of his third year at Fairfield University in Connecticut.

But his father encouraged him to finish the senior year, telling him he could never learn too much.

So he took a full load that senior year before beginning St. Louis University School of Medicine.

The decision to go to medical school had not been any sort of revelation.

Dr. Tedesco thought about law school and business school. The family business was his if he wanted it.

"I believe in my heart that if I'd chosen to be a lawyer or a businessperson, I would have been successful at that."

His father had taught him the basic ingredient of commitment to whatever task.

"In medicine, it turned out to be very, very easy. It's a very rewarding field, because not only do you have the intellectual stimulation which I think is very important, but the fact that it is so rewarding.

"It is an incredible high to deal with people, to be able to relieve their pain or discomfort or actually make a diagnosis in which you can alter a difficult problem for them. That's incredible. The gratitude they express, you can never be compensated for that. That is your biggest reward. I knew early on that I was very content with the decision.

"The more I studied, the more exciting it became."

He was a dutiful student. "I never crammed. I studied every day. I never stayed up late at night studying for an exam." He loved to study. "The challenge of learning was wonderful."

He was fortunate, too, to find role models in medicine and education as he had in other aspects of his life.

Two such models were Drs. C. Rollins Hanlon and Vallee L. Willman, surgeons on the faculty of St. Louis, who gave extra time to the students, either before the regular work day began or Saturday mornings.

Taking advantage of the offer necessitated the students being at the hospital about 4 a.m. That early rising became a habit for Dr. Tedesco. He can be found on the MCG campus long before sunrise.

When it came time for a residency, he opted for internal medicine with an eye toward further specialization. Just four months before his residency ended, he settled on gastroenterology.

"I like the technology associated with gastroenterology. I like doing endoscopy. I like doing things with my hands."

He took a two-year fellowship at Washington University School of Medicine in St. Louis.

"I liked the teaching environment. It was very exciting to be around people always on the cutting edge.

It was very stimulating and still is.''

These things cemented his decision to go into academic medicine.

''You don't have to be in academic medicine to be an outstanding physician or a caring physician, there is no question about that.''

But for Dr. Tedesco, academic medicine offered a stimulation and challenge that was made to order.

As he moved from learner to teacher, he also was touched by the eager, inquisitive minds of students who ask why and why not and daily provide intellectual challenge.

As research fellow, he was working with a faculty member at Washington University to remove a polyp from a colon when he noticed some little bumps in the colon he'd never seen before.

Dr. Tedesco asked his attending about the bumps and his attending gave the honest reply that he didn't know. He told Dr. Tedesco to remove the polyp and to biopsy the bumps if he wished.

This inquisitiveness led to the discovery of an inflammatory process, or colitis, that can be caused when an antibiotic called clindamycin causes an overgrowth of bacteria leading to inflammation of the colon.

His findings thrust him into the limelight and early on set a pace for Dr. Tedesco's career.

He testified before a U.S. Senate subcommittee and the Food and Drug Administration about his findings. He was invited to give grand rounds at the University of California at Los Angeles but couldn't because of a scheduling conflict.

Later, Dr. Tedesco learned that while he was at UCLA he was supposed to see Alfred Hitchcock who was suspected of having this antibiotic-associated colitis.

The Physician's Desk Reference, which lists drugs, their purposes and their side effects, was modified to include the problem Dr. Tedesco found related to clindamycin.

Follow-up led to the discovery that the treatment for this colitis was another antibiotic.

He remained for a year on the faculty of Washington University, then moved to the University of Miami School of Medicine. He quickly moved from assistant professor to associate professor and co-director of a clinical research unit.

Here Dr. Tedesco was again to become a visible man.

He looked at hundreds of patients who had rectal bleeding but had negative single contrast barium enemas or enemas that indicated diverticulitis, a fairly common inflammation of the colon.

Single contrast enemas were the standard method for determining whether patients had serious problems causing the bleeding.

But Dr. Tedesco found using colonoscopy, a more invasive procedure, that anywhere from 35 to 40 percent of the time there was some serious problem such as a polyp or cancer in these patients who appeared to have no serious problems.

That finding had an impact on the way medicine is practiced. It also meant that when President Ronald Reagan had his first polyp, Dr. Tedesco was called for a consult.

Dr. Tedesco stayed in Miami for three years, but by then he was looking for new challenges.

One of his old medical school classmates, Dr. J. Peter Rissing, told him about MCG where he was working.

Within a few months, a job opened at MCG that seemed made to order.

A decade ago Dr. Tedesco became chief of the section of gastroenterology at MCG.

''I thought it was a section that I could make relatively quickly reflect how I thought about gastroenterology. To me, it was a section that had infinite potential.''

It was everything Dr. Tedesco imagined.

But after a time, it became obvious to Dr. Tedesco that he had accomplished much of what he wanted for the section of gastroenterology.

About that time, Dr. Jesse L. Steinfeld was named fifth president of MCG. He began to restructure the MCG administration and asked Dr. Tedesco to be vice president for clinical activities.

''That probably is what kept me in Augusta,'' Dr. Tedesco said. From the third floor of the MCG Administration Building, Dr. Tedesco's career at MCG became somewhat more global.

He became involved in reviewing existing clinical facilities to determine needs and ways to meet those needs.

The Specialized Care Center, which will enhance emergency, trauma and intensive care capabilities of

MCG, and the Ambulatory Care Center, which will consolidate and enhance outpatient care, are the results of these efforts fostered by Dr. Steinfeld and carried out by many people like Dr. Tedesco. These buildings are scheduled for completion in early 1991.

He was able to create a patient care policy that clearly defined the need to have a broad spectrum of patients at MCG so that students and residents could get broad-based exposure.

"I think we are a very major resource in the community. I say that because I believe that. But I also know there are things we have to do to fulfill our mission as an academic health sciences center. One of those things is to take care of patients and to make sure that we provide the environment for both an outstanding educational program and a program where we can recruit the very best people to our faculty.

"If that is interpreted or translated as being more competitive, then so be it. But if we were to just have referred patients, we would be teaching on a very small component of what the graduates are going to have to know when they get into practice."

As Dr. Tedesco delved into the many issues of clinical activities at MCG, he seemed to find a new home.

Then in 1986, a new challenge surfaced. He was asked to serve as interim dean of the MCG School of Medicine.

"I did it with the understanding that I would do it as if I would be doing it the rest of my life. We would not just maintain status quo. We would go on to develop new programs and do new things, that I would run the School of Medicine. That's what really happened."

The more Dr. Tedesco did the job, the more he loved it.

He decided early to apply for the job permanently.

As he became further involved in administration, it meant that his time for patient care was significantly impacted.

"I feel very strongly for you to be a patient's doctor, you are making a commitment to that patient, not only an emotional commitment, but a time commitment. What I found, even as dean, was that my day was getting to be less and less of my own. I don't think it's fair to a patient when they call their doctor to have to get a call back either the next day or 18 or 20 hours later. I feel uncomfortable with that."

So, first as dean, and now as president, Dr. Tedesco has gradually moved into a role he defines as expeditor of patient care.

"I get calls from either patients or other physicians. I help them outline an approach. That approach may mean arranging for one of our faculty members to see the patient. It may mean actually scheduling some tests. I think I have the best of both worlds. I still maintain a very good relationship with these patients."

The weaning from patient care has not saddened him, but Dr. Tedesco admits that he is glad it was gradual.

As tradition would have it, Dr. Tedesco was not long to warm the dean's seat.

The opportunity to become president was somewhat double-edged.

He could apply for the job, not get it and be told by the new president that he did not want as his dean a man who wanted the president's job.

And he wondered about an insider's chance at getting the job.

He talked with wife Luann and daughter Jennifer to make this pivotal decision.

"I didn't respond for a long time," he said of his nomination for the presidency. He liked the challenges of being dean and felt himself to be a very viable candidate for the permanent job.

"But as president, I would not only be able to define the directions of one school, but the whole institution. That to me is exciting."

He and Mrs. Tedesco made a philosophical decision to stay in administration and accept the potential gamble.

July 1, he became president.

"I think every day I am more sure that I made the right decision. I think it's going to be challenging, exciting and I'm even more convinced that it is going to be successful."

He sees as his most important role the bringing together of people to define common goals and work together to bring the goals to fruition.

"I think the president's role is to create a management team that goes in that direction. The president also has a role to go to different places throughout the state to try to make people understand what MCG is, what MCG does and how it impacts not only the immediate community but the whole state.

"It's interesting when you find people as close as Atlanta, three hours away, who don't really understand what MCG does. And yet, some of our patients come from that area. They come from all over the state.

"We are the health sciences center for the University System of Georgia and for the state of Georgia. Our success will enhance the state's success in bringing health care technology to the state, in bringing health-related industry to this area as well as other parts of the state.

"I think we should be the group that our legislators, that our health planners turn to when they have difficult issues they have to address related to health care."

So, yes, Dr. Tedesco will be an ambassador for MCG throughout Georgia and beyond. He will meet with alumni, lawmakers, citizens and anyone who wants to talk about MCG.

"I think Dr. Steinfeld's dreams and goals for this institution were on target. I think Dr. Steinfeld anticipated the changing, not only in the way health care is delivered, but also in the attitude of the state toward their educational system and the medical college.

"We have always been a very successful school in educating health care practitioners. They are giving us credit for that and we deserve credit. But they are saying there is more, we expect more from an academic health sciences center."

The mores include scholarly activity such as research as well as enhancing patient care.

"All those are goals that were carefully and critically pointed out by Dr. Steinfeld. I think every one of those goals is still right on target. I think there were probably some misunderstandings, some concern about management style."

But Dr. Steinfeld brought a sense of demand that was not at MCG before, he said.

That sense resulted in development of a master plan outlining the future goals of MCG.

It also made possible the fact that this legislative session, bonds should be issued for the $37 million Specialized Care Center and Ambulatory Care Center, which are crucial to the future of MCG.

The chancellor, the Board of Regents, legislators and the governor all have indicated their support of this effort.

Dr. Tedesco describes his own presidency as an open one that he takes on calmly.

"I am more nervous about the fact that my daughter, Jennifer, is becoming a 13-year-old young lady, a teen-ager, than I am about being president of the medical college.

"I think I have the background to be president. I have outstanding support personnel. I have a very strong faculty. I have a good student body. Why should I be nervous?

"I think we have to do more long-range planning, and we already are doing that. I think we have to anticipate changes. We have to make bold moves. Make new relationships. I also think we have to become stronger in our research ability. I think we have done a good job, but we have to do a better job.

"I would like to believe that in the not-too-distant-future, we will be one of four very strong, interrelated research centers."

Dr. Tedesco wants MCG to work with the Georgia Institute of Technology, Georgia State University and the University of Georgia on collaborative efforts that make the most of each university's expertise.

"I'm content that we have a chancellor and Board of Regents who now feel that this is a high priority.

"The state has the right to expect that its universities will work together to maximize the resources they are given. There will be more things expected of us and more things that we should expect of others."

One immediate goal is to fill the three vacant dean positions in medicine, dentistry and allied health. He hopes to have all positions filled during this academic year.

"I want to enhance the accessibility and relationship of the alumni to the president's office. I intend to participate in alumni gatherings. I enjoyed it very much as dean. I learned that there are a lot of people out there who have a great love for the Medical College of Georgia."

He wants clear communication on campus, with the alumni, legislators and everyone who has an interest in MCG.

Goals and decisions can be misunderstood. "There will be a logical reason for everything we do. Not that I think that everyone will always agree with what we do. But I think they will always understand that it has been a thoughtful process. Our goal is to enhance this as an academic health sciences center. Our goal is not to hurt someone else. I am going to be very available. I don't mind telling people what we do."

Neither last nor least of the immediate goals for MCG is construction of a children's medical center.

"It's something that we need. We already are the children's medical center for the state of Georgia. We have over 60 faculty members dedicated to the care of children. We need facilities to complement the strong faculty we have and the support services for the faculty."

Dr. Tedesco and his wife's own experience with the trauma of a child with cancer has brought this point very close to home.

When Jennifer Tedesco was diagnosed in 1985 as having rhabdomyosarcoma, a soft tissue tumor, her parents could have taken her any place in this country for care. But they kept her at MCG. Jennifer is now in remission and doing well.

"I'm 100 percent sure that there is nowhere else in the country that could have rendered care better than the care she got here. I don't think I understood that as well as I do now, after going through it."

Dr. Tedesco feels lucky to have been able to share those resources, unlucky that his daughter ever needed them.

And he feels a deep commitment to ensure that MCG has facilities adequate to meet the needs of parents and children throughout Georgia.

"I've learned a greater appreciation of the enormous talent and resources that we have at the medical college which I as a faculty member didn't know we had. I would like to extend that opportunity to everyone in the state of Georgia." ■

—Toni Baker

Mary P. Willingham took her first plane ride this past July. She flew to Philadelphia to visit her son, the sole survivor of her four children.

"I thought the plane would scare me to death, but it wasn't so bad," she reflected. She wishes her son weren't so far away, but even though she lives alone, Mrs. Willingham's Athens, Ga., apartment is never quiet for long.

"Sometimes I get very lonely, but it's not long before somebody's over here to liven things up," she said. Neighborhood children stop by frequently just to say hello, as do numerous friends and relatives.

When she doesn't have company, Mrs. Willingham cooks, cleans, and goes to church and community activities. She likes to watch court shows on television when she isn't busy.

When a group from the Medical College of Georgia visited her in August, she was looking forward to her birthday.

"If I live to see Thursday," she said, "I'll be 101."

Mandy Wheeler apologized to her guests that her apartment—a unit of a low-income housing project in Athens—was so untidy. The guests commented that it looked immaculate. Mrs. Wheeler, who lives alone, cooks and cleans for herself, despite the fact that she had a leg amputated some 20 years ago and is confined to a wheelchair.

"When I had my leg and could get around, everything was spotless," she said. "Anyone who knew me knew everything around me was neat as a pin."

Although housecleaning is harder than it used to be, life in general is considerably easier for Mrs. Wheeler. The daughter of slaves, she spent her childhood working in the fields and is illiterate to this day. She and her 10 brothers and sisters grew up impoverished.

"We had to go to church barefooted. We got two pairs of shoes for the year—one for winter, one for summer. If you wore them out, you didn't get no more," she recalled.

But with or without shoes, Mrs. Wheeler never missed church. Does she still attend regularly?

"Yes, ma'am!" she answered, seemingly shocked that anyone would think otherwise. "I'm the oldest member of my church."

She's not sure just how old she is, but she guesses 106. Her niece thinks she's closer to 109.

What are these centenarians' secrets to living long and living well? The ladies themselves can only speculate: Mrs. Wheeler noted that she drinks prune juice for

Golde

Dr. Gloria Clayton is studying vibranc

Years

d independence among the oldest old.

breakfast and long ago gave up her pipe-smoking habit. Mrs. Willingham thinks long life spans run in her family, but she doesn't know for sure: ''My mother never knew her folks. She was stolen by the white folks (as a slave) and never knew how old she was,'' she said.

Basically, both are stumped. ''The Lord's let me live on for some reason,'' Mrs. Willingham said. ''I don't know why.''

Dr. Gloria Clayton, associate professor and associate dean for the undergraduate program of the MCG School of Nursing, wants to find out. She and two University of Georgia professors are principal investigators of a four-year grant to study lifestyles of very old people who've retained their independence.

''There is something special and vibrant about individuals who pass the age of 80 full of life and in reasonable health and functioning,'' wrote Dr. Leonard W. Poon, a principal investigator and chairman of the UGA gerontology department, in his grant proposal.

The National Institute of Mental Health is giving the researchers about $760,000 to study that vibrancy. Drs. Clayton, Poon and Peter Martin, assistant professor of child and family development at UGA, will study 88 people in their 80s, 88 in their 100s, and 88 in their 60s (as a control group). They began their research in April and are still selecting participants.

Although the research is just getting off the ground, Dr. Clayton said several generalizations have already emerged.

''We were originally concerned about finding participants in the centenarian (100-plus) group,'' she said. ''But we've learned that it's easy to find them. There are a lot of 100-year-olds who live by themselves and are cognitively intact.'' One of every 10,000 people lives to age 100, and 38 percent of those live at home, she said.

But though they live by themselves, most people that age have a lot of support. ''They're very well-buffered,'' Dr. Clayton said. ''It's good news that people that age have a good support system. It's clear they're in a protective environment.''

Mrs. Wheeler and Mrs. Willingham both have a steady stream of visitors. Jackie Gilmore, a 17-year-old relative of Mrs. Wheeler, stops by two or three times a week, stays for several hours each time and helps cook and clean.

Dr. Clayton said people need no motivation to reach out to these elderly. ''There's kind of a societal expectation that centenarians need special treatment. It's like a national-monument status,'' she said.

But the researchers have observed

Dr. Gloria Clayton chats with Mandy Wheeler in Mrs. Wheeler's home.

Mary P. Willingham discusses secrets to her longevity.

that a more important element than societal support is the inner strength of the participants.

"The ones we see are still involved in activities—church, social, community, etc.," Dr. Clayton said. "They're very engaged in something; there's something critically important in their lives. These are not people who sit around watching TV. There's something that makes them feel valuable. What that something is seems to vary."

Both Mrs. Wheeler and Mrs. Willingham, for instance, are involved with their churches. Mrs. Wheeler's recently gave her a certificate lauding her contributions. She's also in touch with current issues: she has a bumper sticker on her front door that reads, "Say Nope to Dope."

Mrs. Willingham's door is always open to the steady stream of neighborhood children who seem to regard her as a surrogate grandmother. And both have a lot of pride in themselves and their surroundings. Mrs. Wheeler insisted on donning a wig and dress before having her picture taken.

They also exhibited independence earlier in life. After divorcing a husband who mistreated her, Mrs. Wheeler traveled throughout the country. Mrs. Willingham taught herself to read and write in adulthood, then went to nursing school at night for three years while working and raising her children.

The researchers also have found that the participants deal well with loss and change.

"We're beginning to see that each subject has experienced a great deal of loss," Dr. Clayton said. "But I don't recall a single subject that seems depressed or grieving. They seem to learn to take loss well."

Mrs. Willingham, for instance, is matter-of-fact about the death of three of her children. "I don't think about my children anymore," she said. "The Lord took them to be with Him, and I don't ask no questions, 'cause He knows what He's doing."

These early findings seem to bear out the researchers' hypotheses: that independent octogenarians (ages 80 to 89) and centenarians master skills of adaptation and survival; that activities and opportunities enhance life satisfaction of the elderly; and that such factors as personality and religious beliefs affect physical and mental health and life satisfaction.

A pilot study Dr. Clayton conducted before the research also supports the theories. She and a team of investigators selected 20 octogenarians and eight centenarians. Each completed questionnaires assessing their adaptational and survival skills, physical and mental health, environmental support, time use and individual characteristics. (Current subjects are given similar evaluations and take physical exams before they participate.)

Findings showed the subjects are physically healthy, very active, independent and follow structured, planned days. Most have friends or relatives who check on them daily.

Socioeconomic backgrounds of participants in both the pilot and current study vary. "We've talked to people across the strata of socioeconomics," Dr. Clayton said.

The researchers hope to begin collecting data this fall and plan to analyze it during the last six months of the study. In the meantime, each participant is proving to be a wellspring of insight into happy, independent old age.

"You just keep on living and do right," Mrs. Willingham advised. "You sure can't live long living wrong. You've got to love everybody and keep on living." ■

—Christine Deriso

Seeing the Light

It was a freak accident that took seconds to happen.

Its result will last a lifetime.

Todd Canady was a young man working on his dream. He wanted to fly the big jets and was taking flight instruction in his hometown, Savannah.

Dec. 12, 1987, Todd also was working on his 1973 Camaro when a rubber strap popped off and hit him in the left eye.

"I opened my hands and I looked at my hands because I had grabbed the side of my face. I figured I'd see blood." Todd is a hemophiliac and bleeding always is a concern.

Pain and inflammation followed the trauma. Within a week his vision was deteriorating and there was blood in the eye.

Todd came to the Medical College of Georgia and Dr. Brent C. Norman, an ophthalmologist with special training in care of the retina and vitreous.

In addition to the blood in the front portion of his eye, the pressure inside Todd's eye was elevated. Doctors observed Todd for a few days, but his eye did not improve.

Todd was headed for a rocky course that has included five major procedures on his eye.

During that course he had blood removed from the front portion of his eye and a large clot removed from the base of the eye. The lens of the eye had to be removed and its focusing power replaced with a contact lens.

Inside his eye changes were occurring. Where the large clot had been removed, scar tissue was beginning to form, slowly pulling the retina away from the eye wall.

The retina is the light-sensitive coating lining the inner two-thirds of the eye. It converts light to electrical signals and transmits the signals through the optic nerve to the brain.

Trauma that tears the retina, diabetes that may

Dr. Brent C. Norman discusses treatment with Todd Canady.

result in leaking blood vessels inside the eye, scarring and even opportunistic infections such as AIDS, all can detach this vital membrane causing vision loss and even blindness.

Todd's detachment likely was caused by an incomplete penetrating injury to his eye that led to scarring, Dr. Norman said.

Todd was taken back to the operating room where Dr. Norman tried to remove the scar tissue. When this was not possible, a large cut was made in the retina to free it from the scar tissue. That procedure, called a retinotomy, meant some method would have to be used to get the retina reattached.

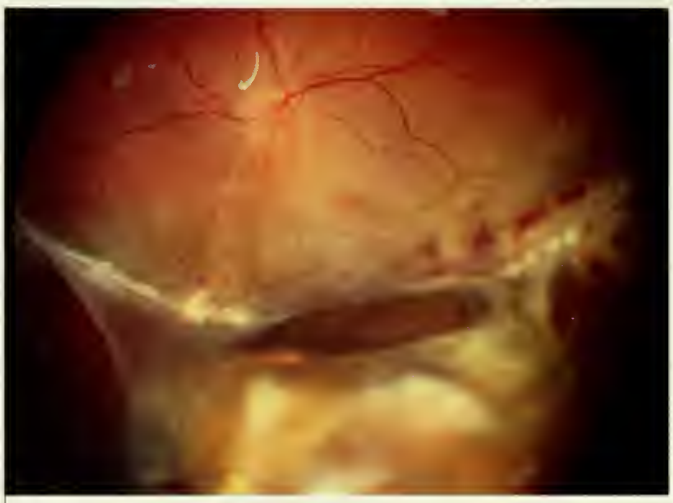
"I wanted to try and give him a definitive procedure," Dr. Norman said.

So he used a laser to reattach the retina, then filled two-thirds of the eye with silicone oil, a substance which offers a permanent tamponade that holds the retina against the eye wall giving it ample time to heal.

More traditional approaches to detached retinas include penetrating the eye with tiny instruments to administer an adhesive such as freezing or a laser light that sticks the retina back where it belongs.

Other approaches are placement of a tight-fitting solid silicone rubber band around the eye to put pressure on the eye wall and stop fluid from leaking between the retina and the wall.

When detachments are more complex, ophthalmologists can combine the freezing or laser technique with a process in which the vitreous jelly that normally fills the eye is replaced with a gas bubble.



Microscopic view shows scar tissue which could lead to recurrent retinal detachment. Photograph by Mike Stanley

The vitreous jelly has the consistency of Jell-O. It not only nourishes the eye, but also works as a sort of shock absorber to protect the eye and exerts pressure to help hold the retina in place. With age, the jelly tends to liquify and can pull away from the surface of the eye actually causing retinal detachment.

The gas bubble used to replace the jelly also works as a tamponade, holding the retina against the wall, but it is only a temporary tamponade.

At most, one type of gas lasts one month; at the least, a gas lasts about seven days. The theory is that the retina will have reattached before the bubble disperses.

"Gas is the standard of care in this country for the treatment of complicated retinal detachment," Dr. Norman said.

Typically he will try gas first and even a second time on complicated detachments.

But in some cases, such as Todd's, the need is for what the ophthalmologist calls a permanent tamponade.

"We've got another method of getting the retina reattached when all other methods fail to hopefully prevent the eye from going to an otherwise blind state.

"The specific gravity of silicone oil is less than that of water," Dr. Norman said. "It forms one oil bubble within the space normally filled with vitreous. The remainder of the eye is filled with fluid produced by the eye. The bubble sits on the surface of the fluid and provides a permanent, intraocular tamponade. In other words, you are putting in a substance that mechanically holds the retina in place, thereby allowing the adhesion to take place."

The silicone oil bubble theoretically will last forever. But because of concerns about the oil emulsifying into tiny bubbles over time, the oil typically is removed within six to nine months.

Also, if the retina stays attached for six months, there is about a 95 percent chance it will stay attached for 10 to 15 years, Dr. Norman said.

Another advantage to the oil is its similarity to the jelly it replaces. "When looking into the eye through a gas bubble, it is kind of hard to see detail in the back of the eye. With silicone oil, it's just like looking through a regular eye. I can see perfectly. I can see detail. I can see new retinal breaks. I can

Dr. Norman performs intraocular surgery on Todd.

see whether the scar tissue is coming back or not. It gives me better control,'' he said.

The permanent nature of the silicone oil has caused debate over whether the oil actually can cause retinal damage by just being in the eye for such a long period.

Some early studies said yes. More recent studies indicate there is no problem, but support removal of the oil at the six- to nine-month interval when its maximum effectiveness likely has passed, Dr. Norman said.

''It's just another tool to allow us to stabilize the eye, to get the retina reattached. What we are dealing with here is the leading edge of retinal detachment surgery,'' he said, noting that oil isn't the final solution, only the progression of the science. In fact, MCG's experience with the oil is part of a national study to compare it with gas.

At this point, the extra tool is a welcome addition to doctors like Dr. Norman who must deal with complicated detachments.

Some detached retinas simply can't be reattached, but silicone oil probably lessens that number, he said.

He has seen the oil salvage at least some vision in an eye that likely would have progressed to a blind state.

Todd is a perfect example.

''I think that basically we are dealing with an otherwise blinding disorder,'' Dr. Norman said. At this point, Todd has some vision in his injured left eye. ''The retina is attached. The functional status of the eye, at this point, is intact.''

He and Todd concur that the results to date are not the best they could have hoped for, but the worst scenario was that Todd would have had to have his eye removed.

''It's depressing sometimes,'' said Todd, an aggressive 23-year-old. ''I want to get through this. I want to get back to work.''

Yet he seems to have an uncanny ability to acknowledge what has happened and keep going.

''At this point, I kind of feel like the $6 million man. I get up in the morning, put my eyedrops in, go about what I am going to do and hope it's going to get better. If it doesn't, there is nothing I can do about it.''

Todd's parents, Peggy and Jake, say Todd has his ups and downs. They know too well how their son feels about not realizing his dream of flying. ''I'd rather be dead,'' Todd said bluntly.

So Todd refuses to give up. ''I'm still going to try to get a license.'' He's convinced he will be successful if he can be considered as an individual, not as some statistic.

''I believe people should be judged on their own personal performance,'' Todd said. How he will get those who grant pilots' licenses to do that, he is not yet quite sure. ''If you have an obstacle, you have to try.'' ■

—Toni Baker

Breaking Ground in Cancer Research

A Medical College of Georgia neurosurgery resident has discovered an immunotherapeutic approach to shrinking and often curing malignant brain tumors in laboratory mice.

Dr. Alfred Bowles, who is working on an American Cancer Society fellowship grant, used antibodies combined with substances called biological response modifiers to shrink the tumors. BRMS are a class of cytokines, polypeptides released from cells to orchestrate intercellular communication. This approach to treating usually incurable brain tumors is new in cancer research, Dr. Bowles said.

Brain tumors are generally treated with surgery and radiation therapy, but a patient's life may be extended by only weeks or months, Dr. Bowles said.

Dr. Bowles first studied the effects of BRMs on brain tumors in vitro (in a test tube) and later on human brain tumor cells grafted into nude (hairless) mice, also in vitro, which are bred to accept the grafts.

Dr. Bowles used two types of BRMs: Tumor Necrosis Factor-Alpha and Interferon-Gamma, both in tissue culture and mouse models. After developing a tissue culture model to measure cellular metabolic activity, he treated the tumors with varying concentrations and combinations of the BRMs. Both BRM types—particularly Interferon-Gamma—were effective in limiting tumor growth in tissue culture.

Injecting the BRMs into the mice yielded even more impressive results: the tumors not only stopped growing, they also shrank with complete regression.

Dr. Bowles then used findings from a separate study by Drs. Cooley Pantazis and Victoria Samuels. Dr. Pantazis, MCG associate professor of pathology, is Dr. Bowles' sponsor.

The study by Drs. Pantazis and Samuels identified certain growth factors that support and maintain tumor growth. Making use of the identification of these growth factors, monoclonal (specific) antibodies against these growth factors were used as treatment agents and were combined with the BRMs to treat the tumors in tissue culture and in the nude mice. The antibody and TNF-alpha combination proved especially effective in destroying the tumors.

The two are pleased with their findings to date but hope to reproduce the results in other types of brain tumors. They also intend to expand their investigation to drug antibody conjugants, antibodies bonded to certain molecules so that they deliver the toxin to specific cells.

"What's really encouraging for us is the concept of monoclonal antibodies and biological response modifiers seems to be working both in vitro and in vivo (in the body)," Dr. Pantazis said.

Phase One clinical trials may be no more than a year away, Dr. Bowles said. These trials would involve assembling a test sample of about 10 patients whose tumors have not responded to any other treatment and treating them with immunotherapy to find an effective dosage. Phases Two and Three would test the efficacy of that dosage among patients with tumors of varying severity.

Although the trials may require more than 15 years' work before the treatment is sufficiently refined, the initial results are already more promising than standard treatment, Dr. Bowles said.

Until recently, brain tumors were considered impossible to treat. Now, even with surgery and radiation therapy, the tumors are likely to return, Dr. Bowles said. It's difficult to remove all the tumor without leaving behind some cancerous cells. Surgeons may be wary of removing too much brain tissue because it's hard to distinguish normal from malignant cells, he said.

Immunotherapy may be the answer because it could be injected directly into the remains of the tumor to kill residual cancer cells and simultaneously to avoid the toxic side effects of systemic treatments such as chemotherapy. No toxicity has resulted from animal studies, and this would be further investigated in the clinical trials.

Dr. Bowles has been working on his fellowship for about a year with Dr. Pantazis and research assistant William Wansley.

—Gwen Corinth

Benchmark

Dear Alumni and Friends

Allow me to introduce myself in my new capacity. In August, I was named acting vice president for development at the Medical College of Georgia and executive director of the MCG Foundation, succeeding John T. Anderson.

Although the position is new to me, I'm a familiar face on campus and to most of you. I joined MCG eight years ago as the accountant for the MCG Foundation and was promoted to director of planned giving in 1986. I have an undergraduate degree and master's degree in accounting from Augusta College.

My new position is but one of the changes at MCG. As you know, Dr. Francis J. Tedesco, formerly the acting dean of the MCG School of Medicine, was named the school's president in July.

I'm excited about the challenges and opportunities that lie ahead. Dr. Tedesco is a dynamic and capable leader. He envisions great things for our institution—things such as a free-standing children's medical center—and we have no doubt he can transform dreams into realities. Enthusiasm is running high and it's great to be involved with MCG at such a progressive point in the school's development.

Of course, you're involved, too, and in a pivotal role. The state of Georgia provides about 50 percent of the total support for educational activities at MCG and about 30 percent of the funds for hospital and clinic operations. Along with internally generated revenue, private support from alumni, friends, business and industry plays a big role in MCG's success. Private giving and endowments have ensured an institution that ranks as a major health education center in the Southeast.

MCG also depends on your time and talent. Special fund-raising events such as the Children's Miracle Network Telethon owe much of their success to your efforts.

So take pride in your accomplishments and help us perpetuate the tradition of excellence. If you're curious about the specifics of making a donation to MCG, read the article, "Medical College of Georgia Gift-Giving Explained," in this edition of *Medical College of Georgia Today.* Commonly asked questions are answered in detail.

Many thanks for your continued support. I look forward to working with each of you.

Very cordially yours,

Bruce L. Howerton
Acting Vice President for Development

Incentives for Excellence

The quality and reputation of the Medical College of Georgia depend on its ability to attract and retain excellent professors and students. Endowed chairs, endowed professorships and scholarships provide a decisive incentive for talented faculty and students, an incentive made possible by your contributions. For while MCG receives financial assistance from the state government, it still relies on private donations to fund programs that bring it distinction.

Endowed chairs and professorships may be established at a cost of $250,000. These funds provide supplemental income for outstanding professors. Recipients of chairs and professorships retain their distinguished positions throughout their tenure at MCG. By their very presence, these honored faculty members inspire colleagues and students to excellence.

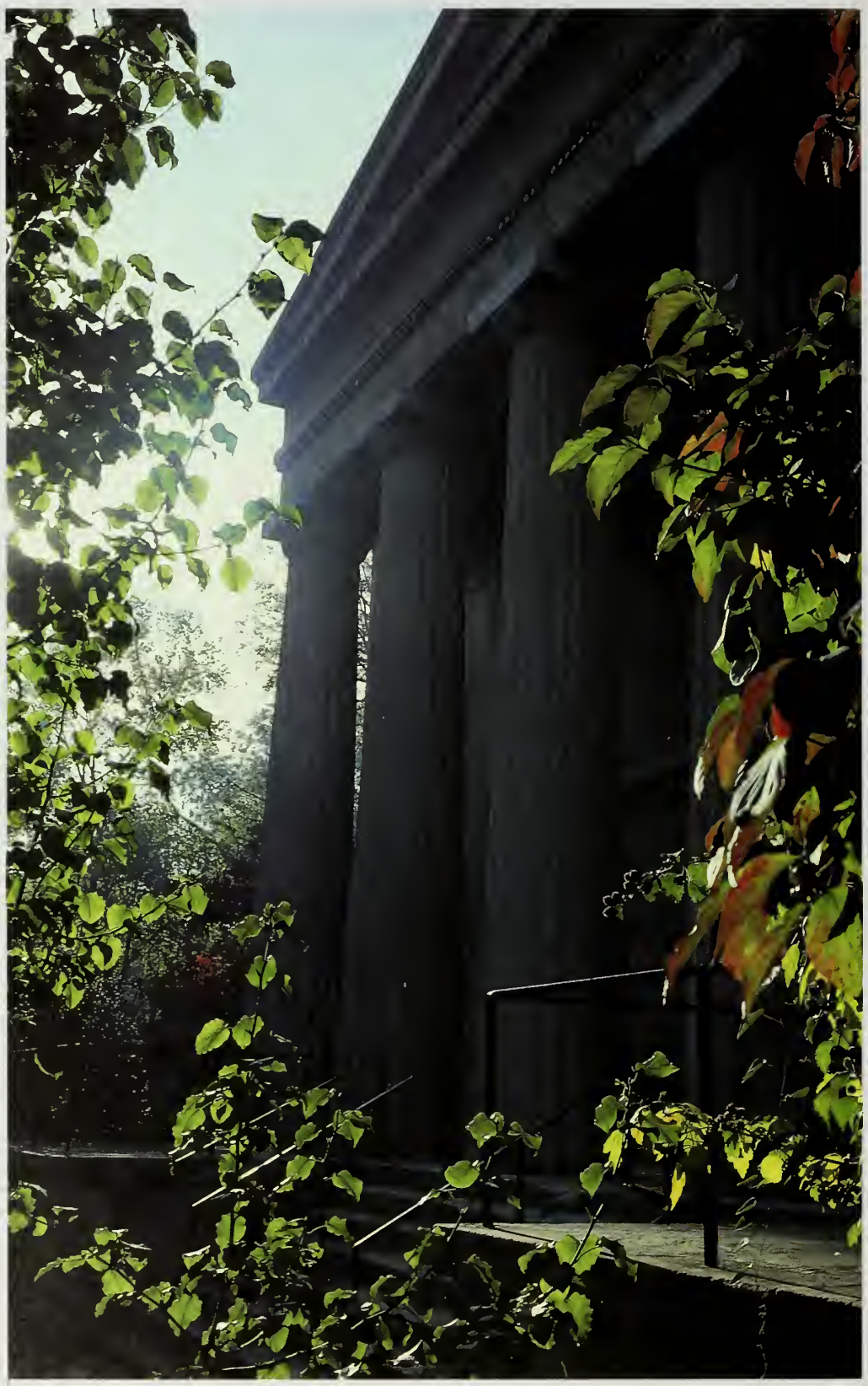
The chairs and professorships at MCG include the Ellington Charles Hawes Chair in Pediatrics, the Robert B. Greenblatt Professorship of Endocrinology and the Sallie Lou Franklin Glover and Katie

Getzen Mealing Professorship of Medicine. We are raising funds currently to establish chairs to honor Edgar R. Pund and William H. Moretz.

In some cases, named endowments are used for purposes other than supplementing salaries. The Curtis G. Hames Lectureship and Professorship in Family Practice sponsors a network of research studies oriented toward the patient as a total person. A faculty member is designated to convene a consortium of 18 to 20 physicians from across the country. This group meets once a year to develop research programs directed toward family physicians in training at family practice residency programs.

The rising cost of medical education has become a serious impediment to many of our best students. To remain competitive with other medical colleges in the United States, we are striving to increase our funding for scholarships. MCG offers a number of scholarships now. In one case, an anonymous donor has provided $5,000 each for three medical sudents and one dental student a year.

For more information about chairs, professorships and scholarships at MCG, contact David McKay, 404/721-4699. ■



Renovation Progressing

More than $800,000 of a $1.2 million goal has been committed toward the renovation of the Old Medical College building. Work is expected to begin by early summer and will span about a year, according to architect Norman Askins.

Final plans for the renovation were approved in January by the Old Medical College Renovation Committee made up of John C. Hagler III, Whitney C. O'Keeffe, and William B. Mullins, M.D.

Plans call for adapting the 153-year-old building for use as a continuing education center while preserving its integrity as a historic landmark.

The main room, library and courtyard have been reserved by donors. The main room is dedicated to the memory of Dr. William H. Doughty, dean from 1910 to 1923. The solarium is dedicated to Dr. William Henry Goodrich, dean from 1923 to 1932. The other reserved areas will be formally named by the donors.

The foyer, rotunda, conference room, parlor and seminar room may still be reserved. For more information about the renovation and ongoing fund-raising campaign contact the Medical College of Georgia Foundation at 404/721-4001. ■

Medical College of Georgia Gift-Giving Explained

Nearly every graduate of an institution of higher education has been approached at one time or another to give money to his alma mater.

Deciding to give is a personal decision and deciding how to give is sometimes confusing. Many giving opportunities are being presented to the alumni of the Medical College of Georgia. Fund-raising projects include restoration of the Old Medical College building; the Children's Medical Center; enhancement of endowments like the Pund Fund, the Moretz Chair, the Ellison Chair, etc.; and scholarship funding, for which there is always a need. Hopefully, there is a project that appeals to you.

This interview with Bruce L. Howerton, acting vice president for development, helps explain how to make gifts to MCG and how to get the most benefit from them.

Q. Why give to the Medical College of Georgia Foundation, Inc.?
A. Contributions from alumni and friends of MCG have historically provided a margin of excellence to the programs and activities of the school. Having read Phinizy Spalding's "The History of the Medical College of Georgia," it is apparent that significant gifts during the college's struggling days kept the college alive. Augusta citizens raised almost $42,000 in 1910 to help stave off the closing of the school. Grants from the Carnegie and Rockefeller Foundations followed shortly thereafter. So giving has had quite an impact on the early history of the college.

More recently, endowments have been created which help attract and support distinguished professors, develop scholarship funds for worthy students and initiate programs like the Children's Medical Center. I think it is fair to say that charitable gifts have had and will continue to have a significant impact on the quality of the educational programs, research and clinical activities of MCG. It truly makes a difference.

Q. How do you make a gift to MCG?
A. The easiest way to make the gift is through the MCG Foundation. This entity was established in 1954 to receive, manage and administer charitable gifts on behalf of MCG. The Foundation administers gifts for almost every program and activity, department and division of the college. A donor's gift can be restricted to any one of these. The Foundation will provide an acknowledgement suitable for tax records which signifies the amount, date and designation of the gift.

Q. How will the Foundation use the gift?
A. That is a very important question. When a donor makes a restricted gift, the Foundation makes a commitment to use the funds according to the donor's intention. The Foundation notifies the appropriate college officials that funds have been donated for specific purposes. Those individuals agree to the terms of the gift and must provide supporting documentation when requesting an expenditure from those funds. Annually, the Foundation is audited by an independent certified public accounting firm which reviews those processes. The success of the college's fund-raising program is determined by our constituents' confidence in our handling of these funds.

Q. What exactly is an endowment?
A. The Foundation often receives gifts which it invests rather than spends. We consider an endowment to be a gift that we invest under professional management and we only spend the investment income from that gift. This ensures a permanent source of funding support to the program designated by the donor.

We also receive gifts from donors which provide current funding for projects. These take the form of scholarships, research, equipment, etc. One example is the Old Medical College of Georgia building project. Funds there will be spent to pay for those renovation costs.

Q. What kinds of properties make good gifts?
A. The most simple and common way to make a gift is by writing a check and I think it will continue to be that way.

But we are constantly trying to point out other alternative gifts to individuals. Any appreciated property is wonderfully suited for a charitable gift. If a donor has owned a stock for more than six months and that stock has increased in value, it makes a very tax-wise gift.

First, the donor can deduct the current fair-market value of the stock rather than his cost. This will provide a deduction greater than the out-of-pocket cost of the gift. Second, the donor does not have to recognize a gain on that appreciation. We get a larger number of gifts of stock each year for those reasons.

Real estate makes a great gift. It is generally very easy to transfer and very marketable.

Gifts of life insurance have become extremely popular in recent years. What makes them so popular is that a donor can know that he is providing a particular amount of support to the school. The improvements in the insurance products themselves have also made the gifts more attractive.

Q. What about giving through a will?
A. An easy way to make a gift of capital to the MCG Foundation is through one's will. All that's required is drafting the will and naming bequest of either a specific amount, a percentage amount or a residual value of the estate to the MCG Foundation.

Q. Will the MCG Foundation help manage an alumnus' assets?
A. Certain donors want to make a donation but need the income of the asset they want to donate. A donor can give money to the Foundation and receive a specific income for the rest of his life. This is good for those on fixed incomes who use it as a supplemental retirement income. And it allows tax savings if the money is transferred during their lifetime. Sometimes, we can increase their income by managing the asset, possibly eliminating an erosion of their principle. ■

Medical College of Georgia

Summary Statement of Current Funds Revenues, Expenditures, and Other Changes

Year Ended June 30, 1988

(With Comparative Figures for 1987)

	1988				
	Educational and General		Auxiliary		1987
	Unrestricted	Restricted	Enterprises	TOTAL	TOTAL
Revenue					
General Operations					
Resident Instruction					
Student Tuition and Fees	$ 4,663,753.00	$	$	$ 4,663,753.00	$ 4,640,024.60
State Appropriations	59,356,513.00			59,356,513.00	56,366,278.00
Indirect Cost Recoveries	1,816,787.32			1,816,787.32	1,957,893.38
Other Sources	167,804.02			167,804.02	102,709.48
Departmental Sales and Services					
Revenues for Program Support	5,009,724.60			5,009,724.60	4,349,649.89
Less: Quasi-Revenue	(1,897,065.84)			(1,897,065.84)	(1,628,751.34)
Sponsored Operations					
Federal Grants and Contracts		7,744,933.55		7,744,933.55	7,404,404.32
State Grants and Contracts		2,833,873.61		2,833,873.61	3,230,717.09
Local Grants and Contracts		485,379.52		485,379.52	446,796.28
Private Grants and Contracts		13,071,786.73		13,071,786.73	12,198,376.68
Endowment Income		106,431.44		106,431.44	120,818.84
Hospital					
General Operations					
State Appropriations	30,609,412.00			30,609,412.00	29,438,910.00
Sales and Services of Educational Activities	89,261,303.18			89,261,303.18	79,878,172.45
Other Sources	8,392.55			8,392.55	50,246.03
Departmental Sales and Services					
Revenues for Program Support	2,999,012.64			2,999,012.64	2,782,819.81
Less: Quasi-Revenue	(573,731.26)			(573,731.26)	(548,464.62)
Sponsored Operations					
State Grants and Contracts		5,196,155.00		5,196,155.00	5,049,233.29
Family Practice Residency Program					
General Operations					
State Appropriations	5,533,945.00			5,533,945.00	5,447,886.00
Desegregation Program					
General Operations					
State Appropriations	356,959.00			356,959.00	338,350.00
Georgia Radiation Therapy Center					
General Operations					
State Appropriations					1,375.00
Sales and Services of Educational Department	2,044,725.72			2,044,725.72	1,640,390.90
Auxiliary Enterprises					
Student Housing			620,455.46	620,455.46	622,335.37
Food Services			694,191.68	694,191.68	585,149.09
Stores and Shops			1,399,403.87	1,399,403.87	1,528,241.65
Other Service Units			1,658,013.75	1,658,013.75	1,502,382.37
TOTAL REVENUE	**199,357,534.93**	**29,438,559.85**	**4,372,064.76**	**233,168,159.54**	**217,059,148.28**
Expenditures					
Educational and General					
Resident Instruction					
Instruction	46,740,480.58	14,803,376.05		61,543,856.63	58,300,666.98
Research		8,151,093.42		8,151,093.42	8,160,861.50
Academic Support	6,738,158.74	42,826.67		6,780,985.41	6,750,494.12
Student Services	1,193,923.11	8,058.37		1,201,981.48	1,075,886.52
Institutional Support	6,821,925.59	703,926.14		7,525,851.73	6,514,967.20
Operation and Maintenance of Plant	7,643,537.11			7,643,537.11	7,481,991.49
Scholarships and Fellowships		533,124.20		533,124.20	449,924.00
Hospital					
Patient Care	106,905,675.41	5,196,155.00		112,101,830.41	101,630,332.65
Hospital Support	7,064,884.95			7,064,884.95	6,712,721.39
Operation and Maintenance of Plant	8,629,296.72			8,629,296.72	8,140,205.48
Family Practice Residency Program					
Instruction	5,495,400.69			5,495,400.69	5,332,058.69
Scholarships and Fellowships					86,000.00
Desegregation Program					
Instruction	257,552.97			257,552.97	242,939.29
Scholarships and Fellowships	99,361.00			99,361.00	95,352.67
Georgia Radiation Therapy Center					
Instruction (Patient Care)	1,887,510.69			1,887,510.69	1,514,613.53
Operation and Maintenance of Plant	157,196.00			157,196.00	127,598.34
Auxiliary Enterprises					
Student Housing			616,649.06	616,649.06	603,687.40
Food Services			874,357.91	874,357.91	835,830.83
Stores and Shops			1,288,570.16	1,288,570.16	1,416,907.51
Other Service Units			1,303,733.25	1,303,733.25	1,094,303.32
TOTAL EXPENDITURES	**199,634,903.56**	**$ 29,438,559.85**	**4,083,310.38**	**233,156,773.79**	**216,567,342.91**
Excess of Revenue Over Expenditures	(277,368.63)		288,754.38	11,385.75	491,805.37
Beginning Fund Balance, Adjusted	99,198.50		22,433.12	121,631.62	59,570.40
Adjustments Other Than State Audit	348,218.56		3,386.23	351,604.79	197,390.42
Lapsed Surplus Returned--Prior Year	(99,198.50)			(99,198.50)	(100,072.82)
Provision for Reserves	19,378.07		(218,603.23)	(199,225.16)	(529,643.12)
ENDING FUND BALANCES	**$ 90,228.00**		**$ 95,970.50**	**$ 186,198.50**	**$ 119,050.25**

President's Club

Members of the Medical College of Georgia President's Club have made lifetime contributions of $50,000 or more and have achieved permanent membership in this giving club. We acknowledge with deep appreciation their generous support.

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Dr. and Mrs. Russell A. Acree Sr. (Lucilla)
Mr. and Mrs. W. Clay Adamson (Darcel)
Dr. and Mrs. Marshall B. Allen Jr. (Dorothy)
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Mr. and Mrs. William L. Amos Sr. (Olivia)
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Dr. and Mrs. W. Herman Brooks (Estelle)
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Dr. and Mrs. A. Clark Robinson (Noma Louise)
Estate of Dr. Horace D. Smith
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Mrs. Vera C. Wardlow
Mrs. Amy G. Warren
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The following members of the President's Club at the Founder's Level have made lifetime contributions of $10,000 or more. We greatly appreciate the generous support of these individuals.

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Dr. and Mrs. W. Jackson Atha Jr. (Vivian)
Dr. Mims C. Aultman
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Ms. Sarah Turner Butler
Mr. and Mrs. Cassius M. Clay (Joan H.)
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The photographs on pages 17 through 23 illustrate various fund-raising activities the Medical College of Georgia sponsored in 1987-88. If interested in participating in future projects, contact the MCG Volunteer Center by calling 404/721-3301.

Dr. and Mrs. William C. Shirley Sr. (Bess)
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It is the goal of this publication to give a special "thank you" to those donors who qualified for membership in a special giving club. Every gift, regardless of size, is sincerely appreciated.

The Medical College of Georgia Physical Plant received the first National Award for Excellence in Facilities Management from the Association of Physical Plant Administrators of Universities and Colleges this summer. MCG was selected from more than 1,400 member institutions in the small-campus category. The award recognizes achievement in facilities management at college and university campuses.

W. Clay Adamson Jr. (above) is the plant director.

Dr. Wesley Covitz is looking for causes.

He wants to know why he sees changes in the hearts of patients with sickle cell anemia.

Sickle cell anemia is a disease in which defective hemoglobin causes oxygen-carrying red blood cells to lose their round shape when the cells give up their oxygen.

The resulting sickle-shaped cells clog the body's blood vessel system, causing pain crises, weakness, organ damage and even death.

Dr. Covitz, pediatric cardiologist at the Medical College of Georgia, is looking specifically at the effects of this disease on the heart and causes for changes.

"All that you see in childhood if you are not a cardiologist looking in a very detailed way at the heart is an individual whose physical performance is impaired," Dr. Covitz said.

"You have to get oxygen to your tissues when you exercise so you have to increase your heart's output. A normal individual who goes from a resting state to a strenuous exercise state has to triple his cardiac output. Sickle cell patients already have a 50 percent higher output just sitting in a chair. Strenuous exercise requires such a high cardiac output that their work capacity is strikingly reduced," he said.

The heart's inability to significantly increase its output might go routinely unnoticed. Sickle-cell patients get good at covering up for lack of stamina by not putting themselves in a situation where sustained activity is required.

But they tire more easily. "It has a significant impact on their quality of life. Most of us judge who we are by

Dr. Wesley Covitz measures Yvonne Harris' blood pressure while she rides a stationary bicycle.

Digging Deeper

what we can do. Physical performance can be anything from being able to participate in sports, dancing up a storm on Saturday night, trying to hold down a job or just getting along,'' Dr. Covitz said.

When Dr. Covitz began taking a closer look at the hearts of these patients, he found changes in the heart occurring as early as three months of age.

He has seen dilatation (enlargement) of the heart's main pumping chamber, the left ventricle. The heart has to eject more blood with each beat because the blood ejected does not have adequate hemoglobin.

''What happens in infant studies is that the heart's contractile strength seems to be impaired transiently.''

By adolescence, their heart muscle has increased in size and strength because of the extra work. In some patients, however, the contractile strength of the heart can become abnormal. There are signs of injury to the heart from inadequate oxygen. The heart walls get stiff so it is even harder for the ventricle to fill with blood on each beat. The heart ends up accepting and ejecting so much blood that it gets muscle-bound, making the heart less flexible and ejection even more difficult.

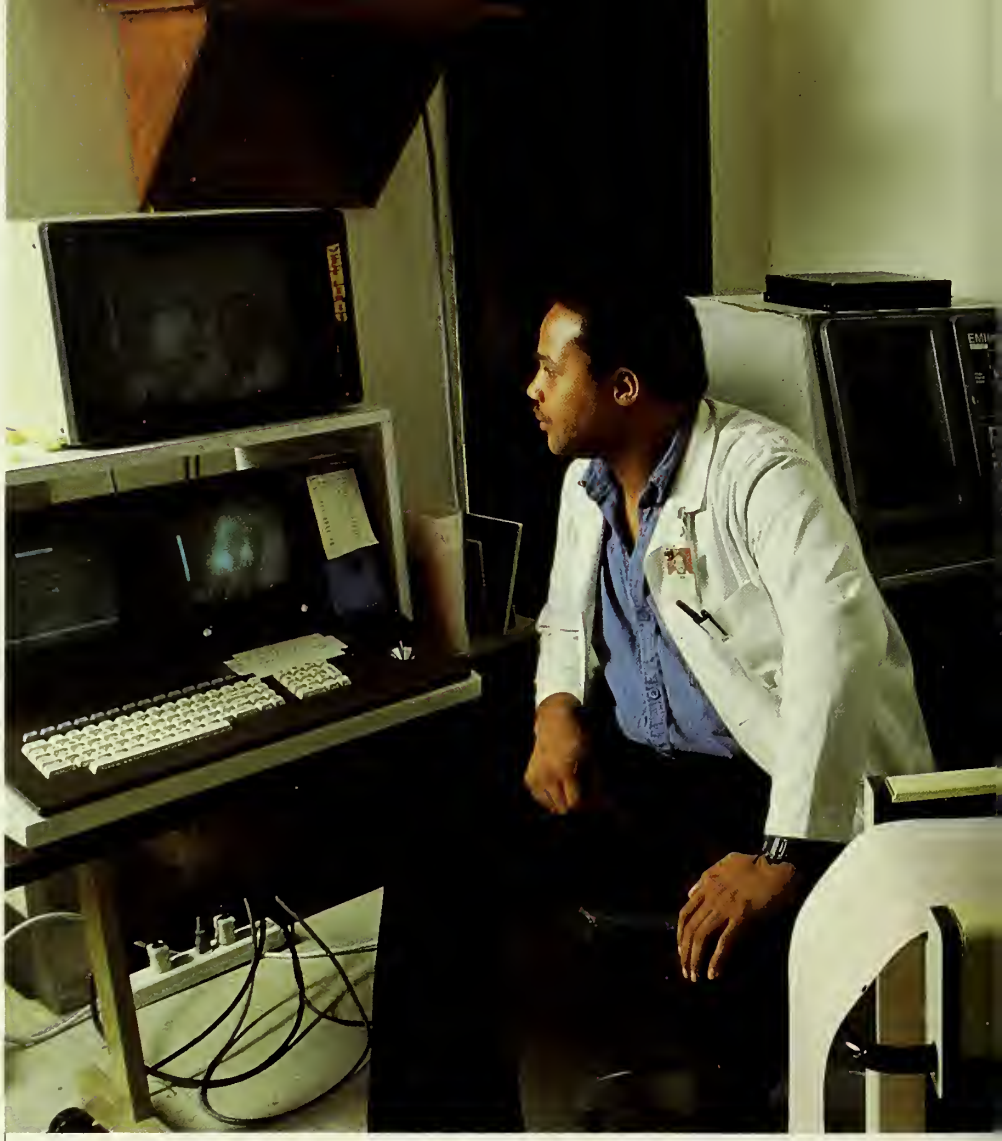
''There is a lot of acceptance of the indirect effect of anemia,'' Dr. Covitz said. ''(But) we feel that the abnormalities that we have found are too much to be explained by just the anemia itself. We believe that the sickling actually causes some clogging of the capillaries of the myocardium and the heart muscle is injured by the sickling effect as well.''

It's a theory and one that Dr. Covitz may end up disproving.

But he intends to know one way or the other whether the heart problems are an indirect result of anemia or if they have a more direct cause.

His main reason for questioning this is the implication that if a direct cause can be identified, treatment may be possible.

''What I would like to do, if I can accomplish this in the next five years, is to do something that will allow these people improved physical performance,'' Dr. Covitz said.



MCG, Yale University, Cornell University and Columbia University are participating in a study defining the heart abnormalities associated with sickle cell anemia.

This study is an offshoot of a 10-year national cooperative study documenting the effects of sickle cell anemia.

MCG also participated in the larger study, funded by the National Heart, Lung and Blood Institute, which just concluded.

Dr. Paul F. Milner, professor of pathology and medicine at MCG, was principal investigator on the 10-year grant at MCG.

Dr. Milner is extending his study to look specifically at sickle cell patients age 35 and older and problems associated with their major organs: the heart, lungs, liver and kidneys.

Meanwhile, Dr. Covitz, is following about 100 patients with sickle cell anemia as part of the focus on the heart. Two studies, five years apart, are done on each patient in the heart study.

Patients come in for complete cardiac histories and physical examinations. Electrocardiograms and echocardiograms are used as screening devices to see if patients can be safely exercise-tested.

If so, Dr. Covitz injects a radioactive substance so the heart can be viewed while patients exercise to capacity.

He measures cardiac output, dilatation and contraction of the ventricles and heart wall thickness.

''So you get a complete profile, not only of what they can perform, but how they deliver it and, if they fail, which of their adaptive mechanisms has failed.

''If the patient exercises and his ventricle fills with blood, as the exercise increases, the ventricle has to contract more forcefully. In the patients that can't deliver, the heart is impaired, contraction becomes less and ejection is reduced.

Dr. Covitz and medical technicians John Greene and Bonnie Hadden study Ms. Harris' computer readout.

"That is a response we see in patients without sickle cell anemia, but with coronary disease," Dr. Covitz said.

To his surprise, he has noted that in these patients, it may not take a muscle-bound heart for the ventricle to get stiff and ineffective in doing its job.

He expected the explanation for the ventricle not filling well to be that the wall was thick and so too rigid to pump effectively.

"But there were patients who had the same situation and the wall wasn't thick. So the stiffness or poor relaxation of the wall could not be explained solely by thickening," Dr. Covitz said.

This observation seems to support Dr. Covitz's beliefs about direct causes.

He theorizes that the tiny capillaries which are fed by the coronary arteries are clogged with sickle-shaped cells, which may explain why the heart walls are stiff when they are not always thicker.

These plugged capillaries can't be viewed even with cardiac catheterization because that common method for viewing the heart visualizes the coronary arteries and these main arteries may be clear, Dr. Covitz said.

So Dr. Covitz also is using MCG's magnetic resonance imager (MRI) to study hearts of sickle cell patients.

These studies are beyond the scope of the cooperative heart study, an offshoot of the 10-year NHLBI study.

But that study also only addresses the effects on the heart. He wants to understand the mechanism for the heart changes with an eye toward intervention.

"If we presume that there is clogging of vessels, we can presume that there are areas of the heart muscle that might be damaged," he said.

The MRI can visualize areas of fibrosis or infarction in the heart muscle.

Dr. Covitz noted that a recently reported study showed that on autopsy, evidence of infarction or fibrosis was found in 17 percent of teen-agers and young adults with sickle cell disease.

"So the whole thing is wide open. It's sort of a pet project of mine to try and prove that theory. If you design your studies well, you may prove yourself wrong."

But he keeps exploring.

A unique population in south Georgia has a combination of genetic disorders—alpha thalassemia and sickle cell anemia. This alpha thalassemia modifies the sickle cell anemia so that these people have sickling of cells without the anemia.

This population affords the perfect opportunity to see if the well-documented changes in the hearts of sickle cell patients are an indirect result of the anemia or if they are caused by sickling.

Dr. Covitz already believes he knows the answer.

"We are going to test them and show that even though they are not anemic, they still have some of these abnormalities and show which ones they have compared to sickle cell patients of the same age and sex."

If Dr. Covitz can show that the abnormalities are a direct effect of sickling, there are at least two approaches to treatment.

"I think it may be possible to give a drug that will effect the filling of the heart which will allow them to have improved exercise performance for a time. I am talking about getting up and going to work, going to school, playing ball or going out on a date. Being alive."

Also, if sickling is the problem and if it can be determined at what point damage is done to the heart, patients could be put on a blood exchange program that replaces some of their own blood with blood that does not contain sickled cells.

"That might reduce wear and tear on the heart and might add 10 years to their lives. I don't know. That is the kind of question we will be asking." ■

—Toni Baker

Labor of Love

Dr. Ralph McKinney was warned as a student that teaching would never be as lucrative as private practice. But he wasn't motivated by money; he was motivated by the love of academia.

When Ralph McKinney told his dental school professors he thought he'd like a career as a dental educator, he didn't get a lot of encouragement.

"They told me I'd never drive a Cadillac," said the chairman of the Department of Oral Pathology at the Medical College of Georgia School of Dentistry. "And they told me that I should try private practice for a while."

Try he did. From 1961 to 1965, he had a general practice in Rocky River, Ohio, a suburb of Cleveland.

Nevertheless, he'd been bitten by the teaching bug, and when the opportunity arose at a nearby college, he became an assistant clinical professor of operative dentistry at Western Reserve University's School of Dentistry.

The time he spent at Western really opened his eyes. Dr. McKinney wasn't new to teaching—he was a student teaching assistant in biology at Bowling Green State University and an assistant instructor of dental hygiene at Ohio State. But the experience showed him there was more to dental education than he'd perceived at Ohio State, and he realized his true ambition.

That ambition led him from Rocky River to the University of Rochester in New York. There, as a postdoctoral fellow in pathology teaching medical students, graduate nurses and graduate students, Dr. McKinney believed he would get the best education in training and educating.

He stayed in Rochester for five years, and in 1970, a teacher he'd admired from Ohio State contacted him about joining the faculty at the MCG School of Dentistry. That former teacher was Dr. Judson C. Hickey, the recently retired founding dean of the School of Dentistry.

"I came here because I knew Jud Hickey at Ohio State. He was one of my teachers and I admired his thoughts as a teacher. He had a lot of innovative ideas in dental education that I thought were different, that I found very interesting. And I had my own thoughts on dental education, too."

During dental school, Dr. McKinney had taken some mental notes. He knew what he'd change about his experience as a dental student and he intended to make things different for his students.

"I would have changed the ability to talk with the instructors," he said. "When I was going through, it was very difficult to get help. I remember feeling totally lost, and I thought there

Dr. Ralph McKinney discusses career amid memorabilia of his trips to the Grand Teton mountains in Wyoming.

should be a way to handle student problems, to work with them and encourage them.''

Consequently, the Department of Oral Pathology has an open-door policy. Students are told early in the quarter to call their professors at home or to make office appointments when questions arise.

''The important thing is that our number-one constituency is our students,'' he said. So he tries to keep things fair, as well as interesting, for the students.

''We go in and tell the students what's expected of them in each course so they can anticipate the quarter,'' he said.

Dr. McKinney thinks teaching pathology requires a creative approach.

''Pathology is different than other subjects. It's not well defined because disease is not well defined,'' he said. ''We try to bring the aspects of disease together and let the students put it in their own words.''

''We approach teaching in a lecture format,'' Dr. McKinney said.

''We want them to come (to class) because the lectures are good, and they do.''

He also thinks educating requires a good deal of listening.

''We're constantly looking for ways to improve our curriculum. We get feedback from the students and then try to be creative with our approaches,'' he said.

Aside from teaching responsibilities, the Department of Oral Pathology has a consulting and biopsy service. They're also busy with oral cancer and oral implants research.

It's a busy department, like many in an academic medical center. But Dr. McKinney tries to unite the department's five faculty members as a team, and he is a mentor to each of them.

''I try to stimulate the faculty to be achievers, creators, to set goals. I help them with their career direction, help them understand what it takes to make it in the academic realm.''

After 18 years at MCG and 35 years in education, Dr. McKinney is glad he didn't get discouraged by his dental school professors.

''I enjoy education because of the diversification. No two days are ever the same; they each hold different challenges. There's the opportunity to share knowledge with the next generation of the profession and the opportunity to grow in terms of scholarly activities.''

But he doesn't have a Cadillac. ■

—Karin Calloway

Travelin' Man

On the road again.

Dr. Donald G. Murphy is headed to Milledgeville, Ga.

His mission there and throughout Georgia is to ask the practicing doctor, dentist, nurse and allied health professional what they want or need to keep abreast of their respective professions.

Then he figures out how the Medical College of Georgia can meet the need.

He travels with a head full of experience, a briefcase full of continuing education offerings and an old milk case full of files in the back of his van.

His first call that day is on Dr. Luis Samper, a pediatrician and coordinator for the Baldwin County continuing education program. Dr. Samper's face is a familiar one.

Ongoing continuing education needs of this health care community bring MCG faculty to town at least every month.

Dr. Samper takes time out of his busy patient schedule to see Dr. Murphy because he appreciates the need for continuing education.

"I am extremely grateful for these programs you do for us," Dr. Samper said. They help the medical staff keep abreast of the real advances in medicine and basic science, he said.

Later that day, Dr. Murphy calls on Baldwin County Hospital and an MCG alum, Dr. James W. Mimbs, who is chief medical officer and director of medical education at Central State Hospital.

He shows the latest in MCG's continuing education wares and asks how MCG can meet the hospitals' needs.

Dr. Murphy is the traveling link that connects these types of needs throughout Georgia with Georgia's health sciences university.

He is assistant director of extension services for the MCG Division of Continuing Education.

This job makes him part salesman, ambassador, marketing specialist, computer operator and traveler.

"I think our mission is to see that continuing education is available to the health care providers in Georgia regardless of where they are.

"My particular mission, for those who don't often leave their practice, the solo practitioner who stays there and works year after year after year and doesn't take much time off, is to bring him the best through our faculty in his location at a time and a place he designates.

"In other words, we are providing up-to-date information to him with the

Dr. Donald Murphy discusses continuing education programs with Dr. James W. Mimbs in Dr. Mimbs' office.

least effort on his part and the least disruption of his practice.''

Dr. Murphy's job is a unique one.

In fact, as best the MCG Division of Continuing Education and the Accreditation Council for Continuing Medical Education can tell, MCG is the only school that has a traveling salesman of sorts for continuing education.

The salesman averages 25,000 miles a year and wouldn't have it any other way.

He likes new horizons.

He's a veteran of 21 years in the U.S. Army flying medical evacuation helicopters in the Korean and Vietnam conflicts.

''It was 1950 and I was entering my first year of law school in Oklahoma City.'' All his friends were being called to war. The United States and its allies were losing badly at the time. Don Murphy decided to put in his two years with the Army then go back to school.

He saw a helicopter buzzing around and figured that would be more fun than flying a desk.

''It turned out to be a lot of work.''

But what work.

He flew into battle to retrieve injured soldiers. He flew fire, flood and mountain rescue missions. He never knew what was coming next and loved it that way, staying on flight status until the day he retired.

By then, law school was long forgotten and education and health care were on his mind.

After retirement, he worked as an administrator for a California-based national health care organization.

About that time, Dwight David Eisenhower Army Medical Center was being established as a regional referral and education center for the Army.

He went there in 1974 to open the education office and help build the residency programs.

Five years ago he made the move to the MCG Division of Continuing Education.

''Every day I can work on something different. I can work with our computer programs. I can go somewhere in the state and speak with people. I can meet someone new.''

His wife has told him he just may love his job too much.

He isn't sure that is possible.

Dr. Murphy rarely makes appointments when he travels the highways and back roads of Georgia.

Experience has taught him he can see most dentists in their offices first thing in the morning, that doctors are back from the hospital and in their offices by mid-morning, that the noon hour is a good time to catch hospital administrators and by the afternoon, doctors and dentists both usually are in their offices.

He's squeezed in between patients and viewed mostly as a welcome sight.

But he does run across physicians or dentists who are angry with the Medical College of Georgia.

''I will sit and listen to him as long as he wants to talk. I will come back and go to the appropriate department with the appropriate school and talk with the chairman or whoever can help alleviate that situation and then get back to that physician or dentist or the department will get back to him.''

This is part of his ambassador role.

As a marketing expert and salesman, he's offering the expertise of the MCG faculty in a package designed to best suit the continuing education needs of Georgia's health care providers.

''I am trying to sell continuing education and more specifically continuing education from the Medical College of Georgia, to sell our national programs, our regional programs and to sell our faculty to them as speakers. So it's a sales job, but like any other sales job, it's a people job.

''We have someone out from the campus several times every week speaking somewhere in the state,'' he said.

MCG provides regular programs in about 24 Georgia hospitals as part of its community hospital program. For some of those hospitals, these programs are their only continuing education programs.

''These talks need to be geared to those type things that the physician or dentist can take back to his office the next morning and implement in his practice.''

Continuing education offerings are as diverse as the needs of the people Dr. Murphy visits.

It may mean teaching a new procedure to a group of specialists, it may mean updating physicians and nurses on the latest in infection control, it may mean certifying instructors to teach courses such as advanced cardiac life support (ACLS).

''It's a lot of extra effort on (the faculty's) part,'' Dr. Murphy said. It may mean juggling schedules, driving hundreds of miles in a day and speaking to a relatively small group.

He's sure some people must grimace when he or Norma Robinson, administrative coordinator for the program, call.

But he brags about a faculty who go well beyond the call of duty in trying to work these continuing education programs into busy schedules.

''Without this dedicated faculty, my job would be meaningless and ineffective,'' he said.

That willingness to help combined with the diversity of the faculty means Dr. Murphy rarely gets requests MCG cannot meet.

On that rare occasion, Dr. Murphy will help the doctor, hospital or other requester find the source that can.

''We are Georgia's health sciences university. As such, I feel we have a responsibility to these people to provide certain things. (Those include) education and information.''

Audience size varies for these programs that may be held in a community with five or 50 physicians.

''It takes dedication to go out and give your best to a small group,'' Dr. Murphy said. ''But it's a great opportunity for our faculty to go out and meet physicians face to face so the physicians will know someone they can call if they have a question, need a consultation or a referral.''

He noted a regular program held in Adel, Ga., a small community with a modern hospital and an obvious desire to learn.

''The program is supposed to last an hour. Sometimes, four hours later, they are still going strong. They wring every last bit of information they can out of a speaker. Our people just love to go.'' ■

—Toni Baker

Going for the Gold

Ronald Wayne Courson was plucked from his high school peers by a wrestling coach looking to fill the smallest weight class on his team.

The coach and the experience were impressive.

Maybe Ron would be a high school coach.

Maybe not.

"I used to wonder when I was in college," he said.

Ron stopped wondering when he learned about a breed called the athletic trainer.

"I wouldn't trade it for anything," said the president of the MCG physical therapy class of 1989.

In athletic training, Ron works with coaches, combining the opportunity to prevent injuries in the well-tuned bodies of athletes with the chance to restore excellent health when injury transforms athletes to patients.

Every professional team, college and even some high school athletic programs now have these athletic trainers. They observe practice, looking for injuries. They use preventive techniques like wrapping and taping to help prevent injuries. When injuries occur, they evaluate, treat and rehabilitate the athlete. They even work with the food an athlete eats to maximize his health and well-being.

"The vast majority of injuries occur in competition or practice. You want to have somebody on site that can say what is wrong and whether the athlete needs to see a doctor immediately or if it can wait," Ron said.

"A lot of coaches aren't really adequately prepared to do that," he said. "And it's not good for a coach to make a decision on whether a kid needs to get back into a game when saving his job depends on how well the team does."

The desire to optimize his professional skills led Ron to pursue a physical therapy degree at the Medical College of Georgia.

"It enhances your credentials. It's going to give me a lot more experience, just a broader education base," Ron said of the physical therapy degree he is earning. And seeking this additional training is becoming a trend in the world of athletic trainers and sports medicine.

"Whatever sport you are in, you always have a goal, whether it's to win a little league championship or to go the Olympics or to make a professional football club," Ron said.

"It applies the exact same way to a patient. Their goals are just different. They want to return to their job. Or, they want to be able to do the recreational activities they did before. Or they just want to be able to go back and live their normal lifestyle," Ron said.

The field excites and challenges him.

It also took the 27-year-old across the world to the finest amateur athletes each country can muster.

Ron was an athletic trainer for the Summer Olympics which was held Sept. 17 through Oct. 3 in Seoul, South Korea.

He was selected by the United States Olympic Committee for the team of five physicians and 14 athletic trainers that served 650 American athletes for the summer games.

"I guess it's something you always dream about as a little kid, about getting to go the the Olympics. It's a once-in-a-lifetime opportunity," said the self-described retired athlete.

The opportunity was the result of a lot of effort Ron already has devoted to his profession and to the Olympics.

He earned his bachelor of science degree in physical education and education from Samford University in Birmingham, then began night course work at the University of Tennesseee at Chattanooga toward a master's in physical education while taking prerequisites for physical therapy.

He worked at the University of Tennessee as a graduate assistant athletic trainer with the intercollegiate athletic program. On weekends and off-time, he volunteered as a physical therapy aide at Erlanger Hospital in Chattanooga.

Along the way he also worked as an exercise technician at Sports Medicine and Fitness Institute in Birmingham, as head student athletic trainer at Samford, as student assistant athletic trainer for the now-defunct United States Football Leagues' Birmingham Stallions and he worked as an athletic training assistant at the training camp of the Indianapolis Colts.

"That was really fun," he said of time spent with the Colts. The professional football players were just normal people. But with them, he said, it was apparent that sports is not only a pleasure, but a business.

"His body becomes more important to him for that reason," Ron said. "He has to be healthy in order for him to go out and work."

In the summer of 1985, Ron got his first taste of the Olympics as a selected volunteer athletic trainer for the U.S. Olympic Training Center in Colorado Springs, Colo. The next summer he was a U.S. Olympic Festival athletic trainer at a national event designed to develop and promote amateur Olympics in this country.

Last year he worked in Yugoslavia as a trainer with the U.S. track and field team at the World University Games.

In 1988 he reached the top rung with the once-in-a-lifetime opportunity to work at the Olympic Games.

He knew for a full year before the games he'd be working with these premier athletes. This chance will delay his graduation by about six months and was made possible by the flexibility offered by the MCG Physical Therapy Program.

Ron is now participating in some extra sports medicine affiliations until he can start school again in January.

But all the shuffling appears to be worth it.

"You have to admire somebody who has put that much work and applied that much discipline," he said of Olympic athletes.

"They have dedicated themselves to be the very best at something they can be and have put countless hours of work, effort and sweat into it.

"I think a lot of Olympic athletes are blessed with natural, God-given talent. But it still takes a tremendous amount of work and desire at that level, because it's world-class competition, the very best in the world," the young trainer said. "I'm happy to help in any way that I can."

Ron also sees the athletes as having a task that is perhaps larger than that of the athlete; the role of being an example and a role model for the United States.

In July as he looked toward the Olympics and talked about the experience, his itinerary looked like this:

Aug. 6 Ron was to fly to Santa Barbara, Calif., for a mini-camp with the track and field athletes that lasted until the end of the month. Then on to Los Angeles for a pre-Olympic stop to check out all track and field athletes before the flight overseas.

Sept. 5 they were to fly to Chio, Japan near Tokyo, for an assembly of the track and field team. Here the athletes got used to the time and climate changes before flying on to Seoul.

The Olympic Village in Seoul was designed to offer everything the athletes need from medical care to a post office.

Ron, Karen Middleton, an athletic trainer and physical therapist from Birmingham, Ala., and one of the physicians were assigned primarily to the track and field team. They covered all the practices and meets, looking to prevent injuries, conferring with the coaches, evaluating, treating and rehabilitating athletes with injuries, making sure that pre-competition meals provided the necessary fuel. They also worked in a round-the-clock clinic designed for the athletes.

"It's a once-in-a-lifetime opportunity," Ron said before he left. "It's been a boyhood dream. I'm still having trouble accepting the fact that I'm actually going to be able to go." ■

—Toni Baker

Dr. Robert A. Parrish (center) operates on child.

Living Proof

Anne Moore Jones has never forgotten.

About being the well-loved youngest of three children.

About being a mischievous little girl from Nashville, Ga., far away from home in a place called Augusta.

About being an 11-year-old child with a huge malignant tumor that odds said would kill her.

"I remember exactly where I was when my stomach started hurting."

She was with her family at her grandfather's house in Sparks, near her hometown of Nashville. Her grandfather had been ill. The children were outside playing. They heard sirens in the direction of her grandfather's house. Hearts pounding, they ran back to the house.

"When we jumped this ditch, something in my side grabbed me, like when you pull a muscle or something. It started hurting and it hurt until the next day." Her mother tried the routine stomach pain remedies. They failed. She finally asked her daughter where it hurt. Anne pointed to her side. Her mother reached to feel a huge lump.

It was the beginning of a journey that would lead them first to their family doctor, then to two surgeons in nearby Tifton, Ga., and finally to Dr. Robert A. Parrish and the Medical College of Georgia.

It was March 1973.

Eleven months before, Dr. Parrish had been appointed chief of the newly organized pediatric surgery service. It was the realization of his long-time goal to provide specialized surgical care for children.

He'd fallen for pediatric surgery during his residency training at the University of Tennessee at Memphis.

Dr. Parrish had known almost immediately after he started medical school at MCG that he wanted to be a surgeon.

"I liked the idea of surgery, of somebody coming in with an acute problem that you could usually do something about, by operating on them, getting them well, seeing them recover and go home," he said.

A required course in dog surgery convinced him, so much so that he spent his summer working as an orderly on the surgical wards in the old University Hospital.

When he went to Memphis for his surgical residency, he added a sixth year to his training, focusing on pediatric surgery and thoracic surgery. In 1962 he joined the faculty of his alma mater.

It was a dynamic time for pediatric surgery in this country.

It was becoming more of a recognized speciality. The larger children's hospitals were turning out surgeons who focused on the needs of children. Two-year fellowships for pediatric surgery began developing. The Journal of Pediatric Surgery was born. Its first editor was Dr. C. Everett Koop. The American Pediatric Surgical Association was founded. Later, a matching program for pediatric surgery fellowships was developed.

When Dr. Parrish came back to MCG, he found pediatric surgery patients were seen by surgical faculty on a rotating basis. It was nobody's specific job to take care of pediatric surgery. He wanted the job.

"I like children. There are so many congenital problems with children that can be recognized...and treated. When you correct a congenital anomaly in a child, you've got somebody with a potential lifespan of 70 to 75 years. That's nice to know that you had some part in that."

Advances that produced miniature ventilators to breathe for babies and made intravenous feeding possible widened the scope of help surgeons could offer children.

Then there were children like Anne.

The mass in her belly was a Wilms' tumor, a common solid tumor of the kidney typically found in babies. The older the child, the less chance of cure. Anne still is the oldest child Dr. Parrish has ever seen with this tumor. He speculated that her tumor laid dormant for years.

In the early days, surgical removal of the tumor resulted in a 40 to 50 percent cure rate. Later, when radiation therapy and chemotherapy were combined with surgery, five-year survival rates shot up to about 85 percent.

But Anne was 11 years old.

Odds were against her.

Dr. Parrish told her parents, Gerald and Nancy Moore, that it was touch and go.

Anne knew the odds. She'd pretended to sleep while doctors discussed her case before she arrived in Augusta. She also sneaked a look at her medical record and saw familiar words like tumor and malignant.

"I really wasn't scared." Maybe it was because of her age. Maybe it was because her family had a strong faith and she was confident of a heaven.

Then there was her doctor.

"He was kind of like a buddy, a friend." Anne already had been poked and prodded plenty by the time she got to Augusta. She remembers Dr. Parrish seeing her for the first time, dismissing the troop of medical students and laying his hand gently on her.

She remembers Dr. Parrish talking fishing and hunting with her father. She remembers Dr. Parrish getting her a pass so she could eat in the cafeteria with her mom.

She remembers that the X-rays taken in Tifton offered little hope that the tumor could be surgically removed.

"Dr. Parrish said one day to

Anne Jones, husband Jeff relax at their Bartow County home.

Momma, 'Well, miracles do happen.' My mom very strongly believes that as Dr. Parrish said, that it was a miracle that they were even able to operate much less that I am running around with my one kidney happy as a lark.''

When Dr. Parrish took the tumor out of the ''scrawny'' 11-year-old, the tumor was large enough to hold in his two hands.

Working with Dr. Dorothy Hahn, courses of chemotherapy and radiation therapy were carried out.

Today Anne is a 27-year-old social worker by training who is working with quality control for the Cobb County Department of Family and Children Services. She is thinking about going back into social work, possibly with children or, at the other end of the spectrum, a nursing home. She still remembers a tall attractive social worker at MCG who went out to buy her Kentucky fried chicken and mashed potatoes when chemotherapy had robbed her appetite for nearly everything.

She, husband Jeff and their two bird dogs live in the hills of Bartow County where they fish for trout in the mountain streams, camp, water ski and hunt.

Anne seems no worse for the wear of her early life.

But the experience left her feeling lucky, blessed and a little special. She's thought more than once that maybe there is something she must do with her life. ''There may be just one person somewhere that I could help.''

And it has left her with a lasting affection.

''If something was really bad wrong with me, I would want to go where Dr. Parrish is. Because he fixed everything and made it all right.''

''Obviously, it makes you feel good,'' Dr. Parrish said of playing a part in Anne's story and other successful outcomes.

But as those stories yield big gains, unsuccessful ones net big losses.

''It's hard to see a child die. You never get used to it. If I ever do, I'll quit,'' he said.

''If it were all left up to us, it would be very, very depressing at times. But we've got help from nursing practitioners, particularly in oncology, that play a vital role in emotional support.''

This is when the team approach to care also becomes an emotional support group for families and health care providers.

''We have a lot of help. Without them, it would be difficult.''

Help has grown significantly for the care of these pediatric patients at MCG since Dr. Parrish's early days as a faculty member.

After he began the pediatric surgery service in 1972, Dr. Parrish established a 25-bed pediatric surgery nursing unit so the young patients

Drs. Parrish (from left), Charles G. Howell, senior resident David Rogers and family medicine intern Stacie Wong confer about a patient during rounds.

could be grouped.

He made it possible for surgery residents to rotate through the pediatric surgery service. Several of the residents have been prompted to go on to pediatric surgery fellowships. Dr. Parrish is proud that any resident who wanted a fellowship has been able to secure one of the competitive positions.

It's the residents who have helped hold Dr. Parrish in an academic setting for 26 years.

"I get a sense of accomplishment out of thinking I might have had something to do with training young people to go out and do good surgery."

For the first eight of his 26 years, Dr. Parrish was the only pediatric surgeon at MCG. Then in July 1978, Dr. Charles G. Howell, a general surgery resident, was made MCG's first special pediatric surgery fellow. He was given faculty status in 1979 and selected for a pediatric fellowship with Dr. Koop at Philadelphia Children's Hospital in 1980. Two years later he was back. Now Drs. Parrish and Howell work as a team, dividing up cases and taking call.

By the summer of 1989 a third pediatric surgery attending, Dr. Robyn Hatley, will return to MCG after a two-year fellowship at Chicago Children's Hospital.

"So it's grown from a rotational service to a one-man show to, hopefully, a three-man show," he said.

The numbers also have grown from no more than 200 major procedures a year to 600 major cases per year for Drs. Parrish and Howell.

Growth has come in many forms: increases in trauma patients, cancer patients, neonates with congenital defects and so on.

"I'm glad I got some help," Dr. Parrish chuckled.

"I think we are bulging at the seams right now," he said, noting the phenomenal growth not only in pediatric surgery but in the burgeoning Department of Pediatrics with its many subspecialists.

"I think it has become very obvious to everybody that we not only need more space, but we could better utilize that space as a children's hospital."

A needs assessment for the children's medical center is winding down and a master plan for the center already has been developed.

"We have a real neat situation here in that the town private practitioners in pediatrics are general pediatricians and the medical school faculty are largely subspecialty pediatricians. We think that combination will make a tremendous attraction for a children's facility where we can all put the children in one place and work together." ■

—Toni Baker

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